Health Home State Plan Amendment

Submission Summary

☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.**

Name of Health Homes Program:

RI Opioid Treatment Program Health Home Services

State Information

State/Territory name:	**Rhode Island**
Medicaid agency:	RI Executive Office Health and Human Services

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

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Proposed Effective Date

07/01/2013 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
The Opioid Treatment Programs (OTP) Health Home proposal seeks to provide patients with resources to navigate an often fragmented service delivery system. The target population for this proposal is opioid dependent Medicaid recipients who are currently receiving or who meet criteria for Medication Assisted Treatment. Data shows most patients are between the ages of 31-64, 86% smoke and all either have or are at risk for: COPD, Cardiac disease, Obesity, Diabetes, Hepatitis C, Viral illnesses.
OTPs provide the opportunity for daily contact with Medical and Clinical professionals who have on-going therapeutic relationships with patients. This will enable providers to use existing and enhanced resources to improve the health of patients and decrease inadequate/ineffective medical care. Provision of this service will positively impact the health and welfare of patients, and reduce overall healthcare costs by: Focusing on relationships with primary and specialty care vs. emergency care; Wellness promotion; Routine health monitoring; Pain management; Care management to develop recovery supports that promote self-care.
Each patient would be assigned to a team which may be specialized to their specific healthcare needs. Patients would have an assigned nurse and case manager to: Monitor healthcare needs; Assist with referral, scheduling, and transportation to medical and other appointments; Develop a health plan; Provide health promotion and wellness activities; Facilitate transitions between levels of care; Support recovery needs; Identify and provide resources that support wellness and recovery.
This Health Home model will provide the mechanism to support stronger, formalized relationships between OTPs and community healthcare providers. This offers a comprehensive, holistic approach including diagnosis, treatment, support, education, and coordination improving quality of life, stability, management of chronic conditions, and decreased healthcare costs.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2013	$ 1404000.00
Second Year	2014	$ 6084000.00

Federal Statute/Regulation Citation

Section 1945 SSA

Governor's Office Review

○ **No comment.**

◉ **Comments received.**
Describe:
Governor Chafee has been briefed regularly on the progress of this initiative through biweekly cabinet reports. The Governor's administration is supportive of this effort and OTP Health Homes was submitted as part of the Governor's 2014 budget.

○ **No response within 45 days.**

○ **Other.**
Describe:

Submission - Public Notice

Indicate whether public notice was solicited with respect to this submission.

○ **Public notice was not required and comment was not solicited**

○ **Public notice was not required, but comment was solicited**

◉ **Public notice was required, and comment was solicited**

Indicate how public notice was solicited:

☐ **Newspaper Announcement**

☑ **Publication in State's administrative record, in accordance with the administrative procedures requirements.**
Date of Publication:
(mm/dd/yyyy)

☑ **Email to Electronic Mailing List or Similar Mechanism.**
Date of Email or other electronic notification:
(mm/dd/yyyy)
Description:

☑ **Website Notice**
Select the type of website:

☑ Website of the State Medicaid Agency or Responsible Agency
Date of Posting:
(mm/dd/yyyy)
Website URL:

☑ Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

☐ Other

☐ **Public Hearing or Meeting**

☑ **Other method**

Other	
Name: Consumer focus groups Date: 05/17/2013 (mm/dd/yyyy) Description: Prior to implementation, BHDDH will be holding consumer focus groups at OTPs to solicit patient feedback on the system design and elicit suggestions on health home services that may be most beneficial.	
Name: OTP Patient Consumer Survey Date: 07/30/2012 (mm/dd/yyyy) Description: Patient consumer surveys were randomly distributed and completed by over 700 current OTP patients. This survey requested feedback on several topics related to health home implementation including: current satisfaction with their healthcare, need for health home related services and likelihood that these services would be accessed through the OTP.	
Name: Regular implementation meetings Date: 02/21/2012 (mm/dd/yyyy) Description: The state convened weekly meetings of an implementation advisory committee that consisted of various members of the OTP treatment community. In addition, other parties were invited to participate in planning meetings and included physicians, consumer representatives, and researchers. All parties expressed support of the OTP Health home intiative and provided input into the system design.	

Indicate the key issues raised during the public notice period:(This information is optional)

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Submission - Tribal Input

☑ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☑ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner:

☑ **Indian Tribes**

Indian Tribes	
Name of Indian Tribe:	
Naragansett	

Indian Tribes	
Date of consultation: 03/20/2013 (mm/dd/yyyy) Method/Location of consultation: In accordance with section 1020(i) of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010; P.L. 111-152, the Rhode Island Executive Office of Health and Human Services (EOHHS) is required to communicate with the Narragansett Indian Tribal Chief and the Narragansett Indian Health Center Director, with a copy to the Health Center Director's Assistant. (The tribe may request additional individuals be copied on communications). EOHHS is required to communicate all proposed changes related to the Medicaid Program including State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects, and any proposed changes to benefits and elibility. Communication will occur via eamil and US mail. Notification of this proposal was emailed and mailed to Chief Sachem Matthew Thomas, Health Center Director Autmmn Leaf Spears and Health Center Director Assistant Hayley Harris.	

☑ **Indian Health Programs**

Indian Health Programs	
Name of Indian Health Programs: Narragansett Indian Health Center Date of consultation: 03/20/2013 (mm/dd/yyyy) Method/Location of consultation: As noted above, notice of this proposed State Plan Amendment was emailed and sent via US Mail to Health Center Director Autumn Leaf Spears and Assistant Hayley Harris with an invitation to comment and/or participate in planning.	

☐ **Urban Indian Organization**

Indicate the key issues raised in Indian consultative activities:

☑ **Access**

Summarize Comments
No response received from tribe.
Summarize Response
No response received from tribe.

☑ **Quality**

Summarize Comments
No response received from tribe.
Summarize Response
No response received from tribe.

☑ **Cost**

Summarize Comments
No response received from tribe.
Summarize Response
No response received from tribe.

☑ **Payment methodology**

Summarize Comments
No response received from tribe.
Summarize Response
No response received from tribe.

☑ **Eligibility**

Summarize Comments
No response received from tribe.
Summarize Response
No response received from tribe.

☑ **Benefits**

Summarize Comments
No response received from tribe.
Summarize Response
No response received from tribe.

☑ **Service delivery**

Summarize Comments
No response received from tribe.
Summarize Response
No response received from tribe.

☐ **Other Issue**

Submission - SAMHSA Consultation

☑ **The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.**

Date of Consultation	
Date of consultation: 10/18/2012 (mm/dd/yyyy)	

Health Homes Population Criteria and Enrollment

Population Criteria

The State elects to offer Health Homes services to individuals with:

☐ **Two or more chronic conditions**

Specify the conditions included:

☐ **Mental Health Condition**
☐ **Substance Abuse Disorder**
☐ **Asthma**
☐ **Diabetes**
☐ **Heart Disease**
☐ **BMI over 25**

Other Chronic Conditions	

☑ **One chronic condition and the risk of developing another**

Specify the conditions included:

- [ ] **Mental Health Condition**
- [x] **Substance Abuse Disorder**
- [ ] **Asthma**
- [ ] **Diabetes**
- [ ] **Heart Disease**
- [ ] **BMI over 25**

Other Chronic Conditions	

Specify the criteria for at risk of developing another chronic condition:
Patients will be assessed for the risk of developing another chronic condition using a uniform checklist at each provider site. This form will address high risk behaviors and other risk factors for chronic conditions such as, but not limited to: smoking; obesity; poor nutrition; childhood trauma; risky sex practices; intravenous drug use; history of or current abuse of substances other than opioids; family health history. These forms will be completed at assessment for new patients, at admission to Health Home programs for current patients and annually at each physical appointment.

- [ ] **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:

Geographic Limitations

- [x] **Health Homes services will be available statewide**

If no, specify the geographic limitations:

- ○ **By county**

Specify which counties:

- ○ **By region**

Specify which regions and the make-up of each region:

- ○ **By city/municipality**

Specify which cities/municipalities:

○ **Other geographic area**

Describe the area(s):

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the State will use to enroll eligible Medicaid individuals into a Health Home:

○ **Opt-In to Health Homes provider**

Describe the process used:

◉ **Automatic Assignment with Opt-Out of Health Homes provider**

Describe the process used:
Health Home participants receiving MAT for opioid dependence will be identified via provider or community partner referrals, such as the judicial system, and outreach to prior patients who were discharged due to no contact. Physicians, other providers, managed care organizations,treatment centers, and criminal justice system professionals will be made aware of the integrated MAT system and referral process through a variety of means, including websites and other notices, Grand Rounds, community meetings, and provider agreements.
All eligible patients currently enrolled in Opioid Treatment Programs will be provided a letter explaining Health Home Services and automatic enrollment with information of how to opt-out. Patients will be given the opportunity to meet with Health Home team representatives to discuss their options. All new patients will be given information on Health Homes Services upon admission and the opportunity to opt-out at that time. Opportunities for opting-out will be provided initially and then annually. Patients who initially accept health home services, but who do not consistently participate in any given 90 day period, may be disenrolled by the provider after demonstrated engagement and outreach efforts. Re-enrollment options are always available for initial or subsequent patients who decline health homes. Beneficiaries will be able to agree or decline to receive specific Health Home services during their participation in developing the individualized Plan of Care. Declining Health Home services will have no effect on their regular Medicaid benefits. The Health Home will notify other treatment providers about the goals and types of available Health Home services and involve them in Health Home activities for shared patients. Individuals receiving services
in a hospital ED or as an inpatient who may be eligible for Health Home services will be notified about their availability and referred based on patient choice.

☑ **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

○ **Other**

Describe:

☑ **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**

☑ **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**

☑ **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**

☑ **The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**

☑ **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

Health Homes Providers

Types of Health Homes Providers

☑ **Designated Providers**

Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

☐ **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

☑ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☑ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

All Health Home designated providers will be Opioid Treatment Programs licensed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals as Behavioral Healthcare Organizations. Licensed status indicates that all programs are required to abide by the Rules and Regulations for Behavioral Healthcare Organizations. All OTP Health Home providers are accredited by independent accrediting bodies and certified by SAMHSA.
MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Effective MAT programs also provide services such as physical and mental health care, case management, life skills training, employment support, integrated family support, and recovery support services. Health Home services build on existing MAT resources and infrastructure. Methadone treatment is highly regulated and can only be provided through specialty Opioid Treatment Programs (OTPs), which have provided comprehensive addictions services but with limited integration into the broader health care or mental health treatment systems.

The OTP Health Home is a Designated Provider as described in Section 1945(h)(5). The OTP Health Home builds upon the existing treatment system by developing into specialty treatment centers that provide the six (6) Health Home services in addition to the traditional comprehensive methadone addictions treatment.

☐ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Teams of Health Care Professionals**

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

Describe the methods by which the State will support providers of Health Homes services in addressing the following components:

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,**
2. **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**
3. **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
4. **Coordinate and provide access to mental health and substance abuse services,**
5. **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,**
6. **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
7. **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
8. **Coordinate and provide access to long-term care supports and services,**

9. **Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services:**
10. **Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:**
11. **Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.**

Description:

In the planning of this amendment, the State of RI actively worked with potential OTP Health Home providers. The State would continue to convene regular meetings for as long as needed in the implementation phase.
To facilitate the capacity to use health information technology, BHDDH will actively work with Health Home providers to become viewers and data sharing partners in the State's HIE - Current Care. BHDDH will capitalize on the progress made by our CMHO Health Homes in connecting to the HIE with provisions for compliance with 42 CFR Part II. A requirement to offer patients enrollment in the HIE along with an approved authorization to release is contained in State regulation for OTPs. All of our OTPs have EHRs. The State will coordinate information from the MCOs and Medicaid as has been done with the CMHO Health Homes. MCOs will provide quarterly utilization reports to OTPs along with next day notification of hospitalization.
BHDDH will coordinate efforts with OTPs and the Department of Health's Chronic Disease Self Management program as this relationship was established during the planning process.
BHDDH will use our Client Information database (RIBHOLD) to provide outcome/trend data to providers and prevent dual enrollment with other Health Homes.
OTPs will be supported in transforming into Health Homes through participation in statewide learning activities, monitoring and technical assistance. BHDDH will modify its monitoring/evaluation instrument created for CMHO Health Homes for OTPs. This instrument was well received by providers and HH reviewers as it incorporates self assessment with a departmental review of process and individual cases. Use of evidence base practice and provision of culturally appropriate, quality driven and cost effective services will continue to be a requirement of both licensing and contracts.
BHDDH will provide links to Health Home information on its website as a means of communication with providers and others.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

Opioid treatment programs are uniquely suited to provide health home services to opioid dependent patients receiving medication assisted treatment. Compliant with both federal and state statutes, OTPs are staffed by medical and clinical staff and have daily to biweekly contact with clients in a clinical setting. OTPs providing Health Home services are required to be licensed by the Department of BHDDH and demonstrate compliance with Rules and Regulations as determined through routine monitoring and audits. OTPs are also required to receive certification through SAMHSA and maintain independent accreditation.
To provide Health Home services, OTPs will be required to maintain a specific staffing pattern dedicated solely to the implementation of the six service domains identified by CMS. Staffing will be based on a ratio of a 125 patients per team. Teams will be organized by primary co-morbid condition if numbers allow (i.e. a Hepatitis C specific Health Home team, a COPD focused Health Home team), otherwise, patients will be organized on teams with many comorbid conditions or risk factors present. These teams will be led by staff trained and knowledgeable in the primary health concern of the patient. Presence in particular teams may be fluid based upon changes in the patient's presentation and primary concerns.

The following is a description of each core Health Home team member and their roles:

Supervising MD: The OTP physician has primary responsibility for the overall treatment of the patient.

Care Management:

• Coordinate and review health assessment that identifies medical and wellness needs.

• Provide consultative support to provider Case managers to help identify the physical health needs of individuals and work with relevant organizations to develop a services plan and arrange for the delivery of physical health services as needed.

• Ensure individuals with complex, co-occurring physical health disorders are well understood or being served by primary care providers, as needed through regular phone contact, correspondence, to their medical and health

promotion providers.

• Ensure the Health Home team develops individual's plan of care integrates the continuum of medical, behavioral health services and identifies the primary care physician/nurse practitioner, specialist(s) and other providers directly involved in the individual's care.

• Support the Health Home team develop individual's plan of care that clearly identifies goals and timeframes for improving the patient's health and health care status and the interventions that will produce this effect.

• Attend organizational staff meetings as needed to assess medical status and progress and to coordinate medical and health promotion activities and develop solutions to problems other staff are experiencing.

• Collaborate with nurses in assessment of client physical health, making appropriate referrals to community physicians for further assessment and treatment, and coordination medical treatment
Care Coordination and Health Promotion

• Ensure that individual plans of care clearly identify primary, specialty, behavioral health and community networks and supports that address identified needs

• Ensure OTP clients have meaningful engagement with internal and community wellness and prevention resources for smoking cessation, diabetes, asthma, hypertension, etc. based on individual needs and preferences.

Individual and Family Supports

• Ensure the care plans reflects patient and family or caregiver preferences, education and support for self-management, self help recovery, and other resources as appropriate.

• Communicate/share information with individuals and their families and other caregivers as appropriate.

• With other team members, provide support and education to family members of clients to help them become knowledgeable about opioid dependence, collaborate in the treatment process and assist in their family member's progress.

Referral to Community/Social Supports

• Participate in the development of agencies' policies, procedures and accountabilities (contractual agreements) to support effective collaborations between primary care, specialist and team, including follow-up and consultations that clearly define roles and responsibilities.

Continuous Quality Improvement

• Participates in agency continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management.

• Clinical supervision, education and training of the team pertaining to medical issues as needed.

RN Supervisor: This team member has primary responsibility for the implementation of health homes services and specific care plans. Nurses assist the physician in the monitoring of routine health screens, they conduct regular face-to-face assessments of clients, screen BMI and blood pressure, make referrals, monitor medications and assist in the coordination with outside providers, including hospitals. The RN supervisor is involved in providing all aspects of Health Home services, including comprehensive care management, care coordination, health promotion, transitions of care, individual and family supports, and referrals to community and social support services. The following is a detailed list of RN Health Home responsibilities:

• In collaboration with the team physician, coordinate, schedule and administer agency's assessment of clients' health, making appropriate referrals to community physicians for further assessment and treatment, and coordinate substance abuse treatment with medical treatment. (comprehensive care management),

• Provide ongoing health assessments (identify health issues, behaviors, needs, barriers) and all other assessments which are appropriate for the nursing scope of practice. (comprehensive care management)

• Build relationships with medical providers in the community, which will provide the team with a network of physical health resources. (comprehensive transitional care)

• Collaborate and regularly liaises with pharmacies, labs and community agencies based on consumer's health and wellness needs. (comprehensive transitional care)

• Refer clients to other health providers and other resources within the community when appropriate. (referral to community and social support services)

• Accompany consumers to medical appointments; facilitate medical follow up, when appropriate. (comprehensive care management)

• Provide supportive case management to families by ensuring they receive assistance with patient advocacy, information regarding program, team, or community health and educational resources, and referrals to appropriate community services and/or agencies. (care coordination)

• Support client access to services such as medical appointments, hospitals, transportation, housing services and social programs by methods such as providing health care information and contacting relevant programs/services. (care coordination)

• Act as an advocate for clients. (care coordination)

• Under the direction of the team physician, the nurse will develop, revise, and maintain medication protocols, policies and procedures. (care coordination)

• Provide support and education to family members of clients to help them become knowledgeable about substance use disorders, collaborate in the treatment process, and assist their family member in making progress. (family supports)

• Manage pharmaceuticals and medical supplies. (family supports)

• Facilitate wellness promotion activities such as smoking cessation, chronic condition self management, and nutrition. (wellness promotion)

Master's Level Team Leader /Program Director: A licensed clinician involved with identifying potential OTP patients, conducting outreach, assessing preliminary service needs, establishing a comprehensive care plan, developing an individualized Plan of Care with goals set in conjunction with the patient, assigning Health Home team roles and responsibilities, developing treatment guidelines and protocols, monitoring health status and treatment progress, and developing QI activities to improve care. These individuals are the bridge between clinical and health home services. Team leaders supervise case managers, facilitate team meetings and provide the necessary outreach and patient engagement strategies. Team leaders, in conjunction with the RNs act as the healthcare liaison with community and institutional providers. Team leaders will participate in transitional care meetings and establish working relationships with primary and specialty care practices, along with other specialty behavioral healthcare providers (CMHCs, residential treatment providers). They are involved in providing all aspects of Health Home services, including comprehensive care management, care coordination, health promotion, transitions of care, individual and family supports, and referrals to community and social support services.
• Leads on development of health services plans of the treatment plan meetings; monitor each client's status and response to health coordination and prevention activities; and provide feedback regarding staff performance, and give direction to staff regarding individual cases and supervise members of health home team in the development of wellness and prevention initiatives; health education groups. Oversee primary functions of HH Team, including but not limited to:

a. Provide on-going training to case managers in the recognition and management of chronic medical conditions. (health promotion)

b. Coordinate and integrate disease self-management activities (improve integration within general health

promotion practices practice). (care coordination)

c. Provide effective discharge planning implementation/ continuity of care. (care coordination, comprehensive transitional care)

d. Ensure quality communication with CMHOs, federally qualified health centers, hospitals (troubleshoot when necessary on issues). (care coordination)

e. Develops and maintains working relationships with primary and specialty care providers, including inpatient facilities. (comprehensive care management)

f. Consult with community agencies and families to maintain coordinate in the treatment process.(referral to community and social support services, individual and family support services)

g. Assures that team is meeting overall Health Homes goals. (comprehensive care management)

h. Educate community health referral sources, perform clinical screens and participating, organizing and executing care-coordination and prevention. (health promotion)

i. Design and develop prevention and wellness initiatives. (health promotion)

j. Monitor Health home performance and leads improvement efforts. (care coordination)

Case Manager/Hospital Liaison: Encourage client towards self-management (i.e. if possible encourage direct communication between the consumer-patient/caregiver and primary care provider; meet patients at their level in order to prepare them to self-manage their acute and chronic conditions). Enhance communication and collaboration between clients, professionals across sites of care, potentially reducing medical errors, missed appointments, and dissatisfaction with care. Advocate, make phone calls and facilitate connections when critical need emerges, and coordinate communication with key medical and social services involved with the patient's care upon discharge when necessary.
1. Maintains good working relationship with medical and psychiatric units (know how to function in variety of medical inpatient cultures). (comprehensive transitional care)

2. Engages with the patient upon admission to the hospital. (comprehensive transitional care)

3. Communicate any noteworthy information back to the inpatient staff. (comprehensive transitional care)

4. Engage consumer and family in their discharge plan by providing them with resources and tools that enable them to participate in the formulation of the transition plan. (individual and family support services)

5. Collaborate with inpatient staff regarding discharge planning (determine the level of improvement and resources necessary for discharge). (comprehensive transitional care)

6. Upon hospital discharge (phone calls or home visit):
• Assist client to identify key questions or concerns.
• Ensure Client:
o Understands Medications and know how to take medications as prescribed;
o Has access to a nurse and physician to discuss any potential side-effects;
o Is knowledgeable about indications if their condition is worsening and how to respond;
o Knows how to prevent health problem becoming worse;
o Has information and transportation to all follow-up appointments.
• Prepare client for what to expect if another next level of care site is required (i.e. how to seek immediate care in the setting to which they have transitioned,
• Review with Health Home team transition care goals, relevant transfer information (i.e. all scheduled follow-up appointments; any barriers preventing making appointments), function as resource to team members – to clarify all outstanding questions. (comprehensive transitional care)

7. Establish a plan of return to hospital if clinically appropriate or if the community transition plan is not working. (comprehensive transitional care)

8. Coordinates transportation to drive client home and to ensure they are properly settled i.e. has appropriate food, etc. (comprehensive care management)

9. Provide advocacy in getting appointment, if necessary or if to obtain answers needed to manage condition as necessary upon discharge. (comprehensive transitional care)

Case Manager: The case manager is responsible for the implementation of the care plan. They provide direct support to the client in and out of the treatment setting. They are responsible for the following:

• In collaboration with the team physician and nurse, coordinate, schedule medical assessment of client physical health, making appropriate referrals to community physicians for further assessment and treatment, and coordinate medical treatment. (care coordination)

• Provide practical help and support, advocacy, coordination, side-by-side individualized support problem solving, direct assistance, helping clients to obtain medical and dental health care. (individual and family support services)

• Provide nutritional, education and assistance with grocery shopping and food preparation as it relates to an identified medical issue (e.g. diabetes, etc.). (individual and family support services)

• Provide health education, counseling and symptom management challenges to enable client to be knowledgeable in the prevention and management of chronic medical illness as advised by the client's primary/specialty medical team. (comprehensive care management)

• Collaborate in the treatment process with primary and specialty care providers as required. (care coordination)

• Support the client to consistently adhere to their medication regimens (e.g. phone prompting, MI, etc.), especially for clients who are unable to engage. (comprehensive care management)

• Accompany clients to and assist them at pharmacies to obtain medications. . Accompany clients to medical appointments, facilitate medical follow up. (comprehensive care management)

• Provide education about medical medications (e.g. consistently discussing the purpose of medications, educating through written materials, enlist the help of other clients, etc.). (health promotion)

• Work with inpatient medical services to complete admission and discharge preparation when necessary, utilize personal health record to help patient self-manage, provide coaching/role playing for person's follow-up appointments. (comprehensive transitional care)

• Provide direct assistance to obtain the necessities of daily life, e.g., legal advocacy for consumers involved in the criminal justice system; benefits counseling (e.g., food stamps, home energy assistance, income tax, transportation, etc.). (comprehensive care management)

Pharmacists: Healthcare professionals who focus on safe and effective medication use. They are an integrated member of the health care team directly involved in patient care. Professional interpretation and communication of this specialized knowledge to patients, physicians, and other health care providers are functions which pharmacists provide, and are central to the provision of safe and effective drug therapy. Pharmacists are responsible for ordering, receiving, storing, and providing nursing staff with medication to be administered. They may review patient medication lists for safety and potential interactions.
There will be three positions shared across Health Home sites/agencies. These vital roles require consistency in implementation at each site and will ensure fidelity to the Health Home model.
The first of these positions is an Administrative Level Coordinator. This person will oversee the implementation of Health Home services at all agencies and act as the liaison to the State agencies supporting Health Homes. This Coordinator will participate in team meetings and work with staff to achieve fidelity to this proposed model. The coordinator will strategize with teams to encourage client participation, develop wellness programs, identify potential community partners and assist in outcome evaluation.
The second shared position is that of Health Information Technology Coordinator. The responsibility of the HIT coordinator is to assist programs in the enhancement of their EHRs to effectively monitor program outcomes and to connect with the State HIE or find other means to share meaningful data. Based on experience from the CMHO Health Home, RI recognizes the need to establish, with each EHR, a mechanism for tracking Health

Home service events. This will be one of the first tasks of the HIT Coordinator. The HIT coordinator will work effectively with RI's Health Information Exchange – Current Care – to capitalize on the work that has already been done to include behavioral healthcare information compliant with all confidentiality requirements. The HIT coordinator will work effectively with the State Medicaid office and MCOs to establish linkages for the sharing of outcome data. In addition, the HIT coordinator and Administrative Level coordinator will continue work begun by BHDDH and SAMHSA to incorporate a pilot of the ASAM electronic assessment tool as a standardized assessment in the EHR.
Finally, the State intends to create a position of Health Home Training Coordinator. Provision of Health Homes Services in an OTP setting represents a significant culture shift that will require specific initial and ongoing training. Having a centralized training coordinator not only makes practical sense, but also for the sake of consistency. This person will ensure that all programs have an equal understanding of the goals and implementation of a successful health home program. The coordination of training will consider all disciplines involved in the effective delivery or services by a health home team.
State oversight of the OTP Health Home program will be the responsibility of the State Opioid Treatment Authority housed at the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) and a representative of the State Medicaid Authority. These individuals will work collaboratively with the shared coordinators, and also leadership of each OTP site. These individuals will ensure that programs are monitored for both process fidelity and outcome.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:
All OTPs will be required to sign the following:
Health Homes Certification Agreement

I- Introduction/Mission Statement:

A Health Home is the fixed point of responsibility to provide person centered care; providing timely post discharge follow-up, and improving consumer health outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers, of comprehensive, integrated services. Emphasis is placed on the monitoring of chronic conditions, provision of preventative and education services around self care and wellness. This program is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits.

The OTP agrees to fulfill and maintain the following requirements necessary for certification as a Health Home Provider:

II. Admission

A. Admission Criteria: Clients with opioid dependence that meet state and federal criteria for Methadone Maintenance treatment and are currently receiving financial support through the entitlement program of Medicaid.
B. Discharge Criteria: Adhere to all Rules and Regulations for the licensing of Behavioral Healthcare Orgainizations in Section 28.0

III. Provider Standards:

• Provide quality-driven, cost effective, culturally appropriate, and person- and family-centered health home services;
• The HH team shall maintain staff compliant with competencies, professional qualifications and experience as described throughout the RI Rules and Regulations for the Licensing of Behavioral Health Organizations;
• Have a physician(s) assigned for the purpose of health home team participation to each individual receiving OTP health home services;
• Conduct wellness interventions as indicated based on individuals' level of risk and willingness to participate;
• Agree to participate in any statewide learning collaborative that may be implemented for health home providers;
• Within three months of health home service implementation, have executed a contract or Memorandum of Understanding (MOU) with regional hospital(s) or system(s) to ensure a formalized structure for transitional care

planning, to include communication of inpatient admissions of health home participants, as well as maintain a mutual awareness and collaboration to identify individuals seeking Emergency Department services that might benefit from a connection with an OTP health home provider;
• Agree to a establish a contract(s) or MOU(s) with Federal Qualified Healthcare Centers (FQHCs) and/or primary care centers in the OTP area;
• Establish a process for receiving and accepting relevant information to coordinate care for Health Home participants among the OTP and primary and specialty care providers, including mental health treatment providers. This may include development of data sharing system that includes Electronic Medical Record (EMR)expansion, use of Direct Messaging through the State's Health Information Exchange will help to safeguard privacy of this information and assure compliance with all related state and federal confidentiality regulations;
• Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and providing feedback to practices, as feasible and appropriate;
• Establish a continuous quality improvement program, and collecting and reporting on data that permits an evaluation of increased coordination of care and chronic disease-management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level;
• Develop treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;
• Monitor individual and population health status and service use to determine adherence to or variance from treatment guidelines;
• Develop and disseminate reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs;
• Agree to convene regular, ongoing and documented internal health home team meetings with all relevant providers to plan and implement goals and objectives of practice transformation;
• Agree to participate in CMS and state-required evaluation activities;
• Agree to develop required reports describing OTP health home activities, efforts and progress in implementing health home services (e.g., monthly clinical quality indicators reports);
• Ensure capacity to provide multiple contacts as needed for a team of 125 clients. Contacts can include phone contact, such as coordinating care with other providers and support systems, as well as direct contact with the individual;
• Agree to participate in annual chart reviews by the Department to assure compliance with standards, measures, outcomes and quality care from each team;
• Any compliance concerns regarding program standards, team composition, measure, outcomes or reporting will be reviewed by the Department for certification status.

Health Home Care Coordination Team:

• Develop and maintain a Health Home team that, at a minimum, is comprised of the following: a case manager, who will serve as the central coordinator for health home services, a case manager/hospital liaison, a physician, a registered nurse, a master's level team leader, and a pharmacist;
• Agree to work with centralized members of Health Home Implementation team including Health Information Technology Coordinator, Administrative Level Coordinator, and Health Home Training Coordinator;
• Other health team members may include, but are not limited to: primary care physicians, peer wellness specialists, mental health specialists, employment specialists and community integration specialists;
• Team members shall meet all of the qualifications in the BHDDH "Rules and Regulations for the Licensing of Behavioral Healthcare Organizations;"
• The Health Home Team Staff Composition required to provide services based on a one hundred twenty-five person team is outlined below.* Any deviation from that staffing pattern will require a written proposal to the Department for approval.
Qualifications: Health Home FTE

Master's Level Team Leader 1.00
Physician 0.25
Registered Nurse 1.00
Case Manager-Hospital Liaison 1.00
Case Manager 1.00
Pharmacist 0.10
Total Personnel 4.35

• Monthly census of team composition will be submitted to the Department for review and compliance with the standard.
• Programs will share the following positions:

Administrative Level Coordinator	1.00
HIT Coordinator	0.50
Training Coordinator	0.50

III. Care Coordination Responsibilities:

• Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
• Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and other substance use disorders;
• Coordinate and provide access to mental health and other substance abuse services;
• Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings;
• Coordinate and provide access to chronic disease management, including self-management support to individuals and their families and referrals through the Department of Health's Chronic Disease Self Management Programs;
• Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
• Coordinate and provide access to long-term care supports and services;
• Develop and implement a person centered care plan that is flexible and integrates all clinical and non-clinical health-care related needs and services. Plan is compliant with sections 25 and 26 of the Rules and Regulations for the Licensing of Behavioral Healthcare Organizations;
• Ensure that all services, including mental health treatment, are coordinated across provider settings;
• Behavioral Health Care Organizations in review of their Policies and Procedures are to update all relevant Policies and Procedures to reflect Health Homes;
• Changes in any aspect of an individual's health must be noted, shared with the team, and used to change the care plan as necessary. All relevant information is to be obtained and reviewed by the team;
• Facilitate timely and effective transitions from inpatient and long-term care settings to the community;
• Health home providers will identify hospital liaisons to assist in the discharge planning of individuals, existing OTP clients and new referrals, from inpatient settings to OTPs and mental health treatment if indicated;
• Care coordination may also occur when transitioning an individual from a jail/prison setting into the community;
• A member of the team of health professionals provides care coordination services between hospitals and community services;
• Team members collaborate with physicians, nurses, social workers, discharge planners and pharmacists as needed to ensure that a person centered care plan has been developed and works with family members and community providers to ensure that the plan is communicated, adhered to and modified as appropriate;
• Provide assistance to individuals to identify and develop social support networks;
• Provide assistance with medication and treatment management and adherence, to include referrals for mental health vocational and counseling services.
• Connection to peer advocacy groups, wellness centers, NAMI, RICARES, and Family Psychoeducational programs;
• Provide Individual and family support services to assist individuals to accessing services that will reduce barriers to treatment and improve health outcomes. Support services may include advocacy, information, navigation of the treatment system, and the development of self-management skills; and
• Referral to primary and or specialty care as requested by physician.

Health Homes Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services:

☑ **Fee for Service**

☑ **PCCM**

◉ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☑ **Risk Based Managed Care**

◉ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**

☐ **The current capitation rate will be reduced.**

☑ **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:
For MCO enrollees active with OTP Health Homes, the MCO will leverage the care management provided at the Health Home and will not duplicate services. The MCO will work collaboratively with Health Homes to ensure all the member's needs are met.
For clients enrolled in OTP Health Homes, the OTP is the lead provider for all care coordination/care management services. To facilitate collaboration, both the OTP and the MCO will be provided with necessary data from the Department.
On a quarterly basis, the Department will provide the MCO with a list of their enrolled members in

OTP Health Homes. The format for this file will be agreed upon between the MCO and EOHHS. MCOs store this information in a central database that can be accessed by all relevant staff. On an interim basis, OTP Health Homes will inform the MCO directly of any new Health Home enrollees.

On a quarterly basis, the MCO will send the OTP Health Home a health utilization profile for the most recent twelve-month period, for every new member of the Health Home. The format and transmission method for this health utilization profile will be mutually agreed upon by the OTP Health Home and the MCO. The elements of the health utilization profile will include but will not be limited to physician office visits (primary care and specialty), prescriptions, emergency room (ER) visits, and inpatient stays.

The OTP Health Home will provide the MCO with a high-level summary of the care plan, in a format agreed upon by the Health Home and the MCO.

The MCO will inform the OTP Health Home of all inpatient admissions prior to discharge, and will engage the OTP in a collaborative discharge planning process, whenever possible. Upon discharge, the OTP Health Home will contact the member to ensure all appropriate services and supports are in place to prevent future hospitalization. The OTP will coordinate with the MCO to obtain any necessary authorizations for in-plan services, as appropriate.

☐ **Other**

Describe:

○ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**
Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

○ **Yes**

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**

- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

○ **No**

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

Health Homes Payment Methodologies

The State's Health Homes payment methodology will contain the following features:

☑ **Fee for Service**

☑ **Fee for Service Rates based on:**

☐ **Severity of each individual's chronic conditions**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☑ **Other: Describe below.**

The Rhode Island State Medicaid Plan currently covers methadone maintenance treatment services at OTPs with a bundled weekly rate. As this rate includes treatment and wraparound services that could be considered as health home service, this rate will be reduced for any patient that does not opt-out of Health homes and matched at the current level. RI seeks 90-10 matching funds only for the costs directly linked to providing the Health Home services.
The OTP provider initiates a claim for the weekly rate, using a new procedure code for Health Home services.
As methadone maintenance treatment services are considered an in-plan benefit for individuals with RiteCare, the Health Home payment weekly rate will be reduced to reflect the higher rate paid by MCOs, with the total between the two (MCO payment and HH payment) equivalent to the rate for all other Medicaid clients.

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.
The methodology to develop costs for the Health Home service is based on the cost to employ key health professionals (salary and fringe benefits) who will provide the Health Home services. The staffing enhancements are based on a model of 4.55 FTEs for every 125 OTP patients served. The Health Home payment is a weekly, bundled rate per patient. The OTP provider initiates a claim for the weekly rate, using a new procedure code for Health Home services. The
provider may make a weekly claim using the Health Home code for a patient who receives an average of one encounter per week in one month. Encounters will be recorded in fifteen minute increments and

providers will be required to submit monthly encounter data to BHDDH. The first six months of data will establish a baseline average for encounters per agency and guide a rates review. It is expected that the average rate across HH teams should be significantly higher than billing minimum requirements with utilization based on patient needs.
The weekly rates of $87.52 for FFS Medicaid and $52.52 for RiteCare clients are based on the following Key Employees, the FTE devoted to HH service and corresponding salary:
Medical Director .25 FTE $94,640
HH Coordinator 1 FTE $81,120
Registered Nurse 1 FTE $81,120
Case Manager 2 FTE $108,160
Pharmacist .1 FTE $18,928
Administrative Level Coordinator (shared position across HH sites) .1 FTE $10,816
Staff Training (shared half time position across HH sites) .05 FTE $5,408
Technology/IT (shared half time position across HH sites) .05 FTE $8,112
As described in previous sections, this staffing composition is crucial to the implementation of HH services.
Rates and staffing will be reviewed at six month and one year intervals to assess continued need for shared training and IT positions. It is expected there will be greater need for these positions in the first six months and may decrease thereafter.

☐ **Per Member, Per Month Rates**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (description included in Service Delivery section)**

☐ **Risk Based Managed Care (description included in Service Delivery section)**

☑ **Alternative models of payment, other than Fee for Service or PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☑ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.
RI has developed a two-part payment structure for OTP Health Homes. All payments are contingent on the HH meeting requirements of the certification agreements. Failure to meet requirements is grounds for revocation of HH status and termination of payments. Part One: First Quarter infrastructure cost reimbursement. Part Two: HH weekly Fee For Service Payment as described above in the FFS Service section.

First Quarter Infrastructure Payment: Designed as a start-up, training, and infrastructure payment to reimburse Health Homes for start-up, lost productivity and activities of transforming infrastructure to become a HH. There are significant costs associated with hiring/training staff to perform HH functions and identifying/enrolling an initial critical mass of HH eligible patients. RI proposes to address this in two ways:

(1) A critical mass of patients will be auto-enrolled in the first quarter of operations. These patients will be informed by letter from BHDDH and at their first HH visit of options to choose other HH providers or to opt out entirely from HH services.

(2) During this first quarter, OTPs will need to hire/train new staff. Productivity will be reduced and time will be lost in this process. To account for this, RI proposes a first quarter payment methodology assuming that it will take on average one month to hire the necessary staff and an additional two months to orient/train in both standard clinic operations and new HH operations.
The 1st Quarter start up payment would equal:
# of auto-enrollees X weekly rate X 13.
• 70% of the first quarter infrastructure payment will be paid to the OTP upon successful designation as a HH.
• The remaining 30% payment will be paid when the site has met a threshold of 90% of the required staffing model.

It is important to note that during the first quarter, there will be no fee for service payments made to sites, though persons initially auto-enrolled will receive HH services.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.
There are no 1915(c) waivers in RI - everything is under 1115 demonstration waiver authority. The only payments for targeted case management is to Persons Living With HIV/AIDS.
EOHHS and BHDDH will identify clients who receive targeted care mangement through Ryan White funding and also receiving OTP Health Home services and coordinate on a case-by-case basis to eliminate duplication of services.

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

Submission - Categories of Individuals and Populations Provided Health Homes Services

The State will make Health Homes services available to the following categories of Medicaid participants:

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive Care Management

Definition:
Comprehensive care management is provided for patients, families and supports, to develop and implement a whole-person care plan and monitor the patient's success in achieving goals.
A bio-psychosocial assessment of physical, behavioral, psychological status and social functioning, along with a physical exam, is conducted for each person admitted to an OTP. This determines the appropriate level of care; need for specialized medical/psychological evaluations; need for family participation or other supports, and the staff and/or program to provide the care.
Based on the assessment a goal-oriented, person centered care plan is developed and implemented by a multi-disciplinary team which includes the patient served.
The healthcare liaison, whose primary function is to establish and maintain primary/specialty care provider relationships, provides a process for outreach, planning, and communication. These relationships promote multidisciplinary treatment recommendations and planning by fostering consistent access and communication.
Communication of patient preferences is incorporated throughout the health home process. Consumer driven care plans focus on the desired goals of the patient. Communication with providers will reference patient preference and choice. Case management can teach patients self advocacy to communicate preferences.
Most of the team composition is experienced in the provision of services to OTP patients. Programs will focus on role expansion and training to incorporate the holistic healthcare perspective. Case managers will be recruited and trained in a health home model of care.
Recovering individuals are central to a recovery oriented system of care. Rhode Island has two established recovery support centers able train medication assisted advocates and has a cadre of certified recovery coaches accessible to OTP patients. Upon patient request, Recovery Coaches will participate in planning and implementation of health home services.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
All six of the current OTP providers have electronic health records and the sixth is in the process. Three of these providers use software that is certified for meaningful use - representing more than half of the OTP population. Providers will be encouraged to adopt a standardized assessment tool that can be updated to reflect outcome. RI is in the process of planning a pilot with OTPs to implement an ASAM PPC assessment tool that will provide standardized outcome measures.

OTPs are required to submit patient specific data to the RI Behavioral Health Online Data(RIBHOLD) system at admission, discharge and relevant changes in condition. OTPs will receive training from BHDDH on extraction and meaningful use of the data in RIBHOLD. RIBHOLD data is used to provide outcomes to SAMHSA to reflect changes in abstinence rates, housing, employment, social connections, criminal justice involvement, and retention in treatment(NOMs). The information collected extends beyond these basic measures to include relevant comorbid conditions. Health Homes would provide OTPs with additional training and incentive to use updated data submissions to identify and document the effectiveness of the health home model on multiple outcomes, including health condition.
Care plans established at the OTPs can be shared with multiple providers using the State's HIE - Currentcare. The HIT coordinator position will assist programs in becoming data sharing partners and/or participants in Direct Messaging. This participation will facilitate the sharing of care plans and reduce duplication of effort. Current Care representatives have been and will continue to be participants in the OTP Health Home planning process.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Qualified Behavioral Health Specialists will conduct initial bio-psychosocial assessments and work with patients and other team members to develop care plans. Case managers will be responsible for ensuring adherence to the plan, engaging family members and other supports, and monitoring outcome.
Case managers will assist patients in accessing other specialized care, encouraging patients to keep appointments and follow through with care recommendations.

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
Nurses will assist physicians in the admission and annual physicals. They will assist in the development of the care plan. Nurses will regularly coordinate with other healthcare providers and establish routine communications. Nurses will continue to assess patients throughout treatment and monitor progress in achieving health care plan goals.

☐ **Medical Specialists**

Description

☑ **Physicians**

Description

Physicians review the bio-psychosocial assessments and conduct initial and annual physicals of all OTP patients. Physicians are central to the creation of the care plan and lead teams to identify need for specialized care. Physicians monitor medication stabilization and are available to consult with all other providers.

☐ **Physicians' Assistants**

Description

☑ **Pharmacists**

Description
Pharmacists are available for consultation to the health team to review patient medications and make recommendations to the care plan based on this assessment.

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Care Coordination

Definition:
Care coordination involves implementing an individualized care plan to attain goals and improve chronic conditions. Care managers are responsible for conducting these activities across all settings. This service provides case management necessary to access medical, social, vocational, educational, and other services, including, but not limited to: Assistance in accessing health care and follow-up care; Assessing housing needs - providing assistance to access and maintain safe/affordable housing; Conducting outreach to family members others to support connections to services, and expand social networks; Assisting in locating community services in medical, social, legal and behavioral healthcare areas and ensuring that all services are coordinated; Coordinating with other providers to monitor health status, medical conditions, medications/side effects; Coordinating with other entities such as the criminal justice system, Child and Family Court and DCYF.
Currently OTPs have established relationships with some primary care and medical specialty providers in their regions. Regular contact occurs with hospitals regarding medication verification and continuity of care. OTPs also have relationships with private psychiatrists and community mental health organizations. These linkages can be strengthened and formalized as OTPs become Health Home providers.
Memorandums of understanding are used consistently by OTPs as standard practice when working with community providers. Formal agreements are less prevalent with recovery support services. Health Homes can provide the impetus to expand the recovery support network.
As 42 CFR Part II programs, OTPs are aware of the need for compliant consent forms. The state has established a standardized process to share Part II information with the statewide Health Information Exchange(Current Care). Patients are fully apprised of consent choice and confidentiality regulations as they pertain to substance abuse treatment.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
OTPs will be able to link electronic health records to the State Health Information Exchange - Current Care. Behavioral Healthcare Organizations (including OTPs) are required by regulation to offer enrollment in the Current Care system. Regulations provide access to an approved authorization to release information form that provides compliant data exchange with 42 CFR Part II protected information. OTPs understand and meet the requirements of HIPAA relevant to information sharing. Three of these OTPs - representing more than half of the OTP patients in the state, use certified software. Currently the State receives regular data from the Department of Corrections on OTP patients that become incarcerated in an effort to provide continuity of care. This information is shared with the identified provider. MCOs have developed a process to notify CMHO Health Homes of any hospitalization within 24 hours in an effort to coordinate care. This process will be established for

OTP Health Homes also. MCOs have provided CMHOs with routine utilization reports and will do the same with OTPs so they are able to see where patients are - and are not - accessing care.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
The position with primary responsibility for this service will be case managers. Case managers will seek input from other team members, but will be the primary contact for care plan implementation. Case managers will assist patients in accessing other services by appointment reminding, attending appointments, identifying need and associated resources. Case managers will most often be the team member with the most patient contact and outreach patients and their supports to maintain engagement in services. Case managers will most frequently interact with providers of other services and note compliance with care recommendations. Case managers will report back to other team members on care plan implementation - success and challenges and seek input from others to enhance outcome and goal attainment.

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Promotion

Definition:
Health promotion services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors. The services also enable individuals to self-manage their health. Health promotion services may be provided by any member of the OTP health home team.
Health promotion activities place a strong emphasis on self-direction and skills development for monitoring and management of chronic health conditions. Health promotion assists individuals to take a self-directed approach to health through the provision of health education. Specific health promotion services may include, but are not limited to, providing or coordinating assistance with:
o Promoting individual's health and ensuring that all personal health goals are included in person centered care plans;
o Promotion of mental health treatment, smoking prevention and cessation, nutritional counseling, obesity reduction, and increased physical activity;
o Providing health education to individuals and family members (where appropriate) about chronic conditions;
o Providing prevention education to individuals and family members (where appropriate) about health screening and immunizations;
o Providing self-management support and development of self-management plans and/or relapse prevention plans so that individuals can attain personal health goals; and
o Promoting self-direction and skill development in the area of independent administering of medication.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Information will be collected on a periodic basis on individual participation in both external and internal health promotion activities. For those activities included in the EHR, this information can be shared to other providers using the Current Care HIE. Individuals accessing health promotion activities through the Department of Health's Chronic Disease Self-Management Program will also be tracked by the Department of Health for follow-through, participation and completion. OTP staff have been encouraged to become providers for the DOH programs and train in the Stanford Model along with offering RNs and pharmacists the opportunity to become certified diabetes outpatient coordinators and certified cardiac outpatient coordinators.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Master's level team leaders will be responsible for the oversight of this service. Care managers may assist in the provision of health promotion activities.

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
Health Home team RNs will have primary responsiblity for the provision of health promotion activities. Nurses will create and facilitate groups targeting health promotion (i.e.nutrition, smoking cessation, exercise)as well as meet with participants individually to monitor and encourage health promotion activities. Nurses will provide educational materials to individuals and be available as primary consultants for any questions related to health promotion activities.

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Physicians will have routine contact with Health Home patients and will encourage participation in health promotion activities.

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Definition:
Comprehensive transitional care services focus on the transition of patients from any long-term care facility or other out-of-home setting into the community. Health Home team members work closely with the patient to transition smoothly back to the community and share information with discharging organizations to prevent gaps in care that could result in re-admission.
To facilitate timely and effective transitions, all OTPs will maintain collaborative relationships with emergency departments, local hospitals, long-term care and residential facilities and other applicable settings. OTPs will utilize healthcare liaisons to assist in discharge planning - existing OTP patients and new referrals - from inpatient settings to OTPs. Care coordination will also assist in transitioning incarcerated individuals.
Healthcare liaisons, care coordinators and other team members will provide transitional care services. The team will collaborate with physicians, nurses, social workers, discharge planners and pharmacists within the hospital or residential setting to ensure a care plan has been developed and work with family members (where appropriate) and community providers to ensure that the plan is communicated, adhered to and modified as indicated.
When an OTP patient is admitted to a hospital, there is dialogue with medical staff for dose verification. Education will be provided to hospitals regarding OTP health home services and this dialogue can be expanded beyond dosing information to continuity of care and discharge planning.
Rhode Island's experience with the Health Homes for the SPMI population benefits us by providing an established procedure for information sharing on healthcare utilization. Managed Care Organizations and Medicaid have created mechanisms for monthly utilization reports provided to CMHOs. This practice will be replicated for OTPs. MCOs have developed next day notification procedures to health homes on all hospital admissions.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Health information technology is crucial in establishing effective, comprehensive transitional care. Currently, all OTPs have electronic medical records, though may not be able to share health record information easily. In the start up phase of this Health home initiative, providers will be encouraged to participate in Direct Messaging available through the State's Health Information Exchange - CurrentCare. Direct Messaging allows providers to share information securely and efficiently.
Data that is submitted through RIBHOLD is currently accessed online, by the providers to prevent dual enrollment. If a client is currently active in one program, another will not be able to admit until that client is "cleared" for admission by being discharged. OTP providers are very accustomed to using this form of HIT to coordinate care amongst themselves. Easy access to enrollment data allows providers to request prior treatment information that will assist them in development of a comprehensive treatment approach.
BHDDH also receives daily census data from the Department of Corrections in order to alert providers that an active OTP patient has been incarcerated and to provide continuity of care during at least the initial period of incarceration.
Through a collaborative process with MCOs, OTPs will be provided with quarterly utilization reports for their clients, enabling them to address need for coordination and transition. OTPs will also receive

next day notification by MCOs on any Health Home patient that is hospitalized. These standard reports will be submitted to OTPs on a regular basis and assist in the effective provision of transitional care services.
OTPs have relationships with providers of long term care services including nursing facilities and substance abuse residential treatment. These providers may also participate in direct messaging enabling OTPs to provide and receive information enhancing their ability to meet client needs in transitioning.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

All members of the Health Home Teams

Description

This service is an essential service for all members of the Health Home team. The Master's Level team leader will need to assess the consistency of the care plan(s) established in relation to the clinical treatment plan. This person will interact with other providers in addressing the patient's treatment and health needs while in another setting and work with the team to establish a transitional plan.

The team physician will be responsible for the review of other treatment received and re-integration in the outpatient setting. Physicians will need to coordinate with other physicians to ensure continuity of care. Physicians will guide other team members in the establishment of a transitional care plan.

The registered nurse will likely be the primary provider/monitor of transitional care activities. Nurses have the most day-to-day interaction with other physical health care providers. Nurses are responsible for the oversight of medication delivery and administration. The RN will be the party responsible to develop the transitional care plan and accomodate any of the needs of individuals, such as transportation, ambulation, and risk of infection.

The case manager will be responsible for the application of services in a transitional care plan. The care manager will be responsible for assuring the patient is able to follow through with transition plans and is assisted in doing so.

The hospital liaison will work closely with the hospital staff, especially discharge planners, to assess the suitability of transition plans. Hospital liaisons will work with other long term facilities to plan for coordination of care during and after a residential stay.

Patients transitioning from long term programs or hospitalizatons may have the need for a medication review by the pharmacist to ensure that medications prescribed during or post these stays will not interact with methadone.

Individual and family support, which includes authorized representatives

Definition:

Patient Support Services provide quality care that allows clients to maintain independence and improve the quality of their lives. This support may involve families, communities, professionals and any other entity identified by the patient as integral to their recovery process. Individual support services, including family where appropriate, are provided by the care coordinator and other members of the health team to reduce barriers to individuals' care coordination, increase skills, engagement and improve health outcomes. These services may include, but are not limited to:

o Providing assistance in accessing needed self-help and peer support services;
o Advocacy for individuals and families;
o Assisting individuals to identify and develop social support networks;
o Assistance with medication and treatment management and adherence;
o Identifying resources that will help individuals and their families reduce barriers to promote the highest level of health and success;
o Connection to peer advocacy groups, wellness centers, Rhode Island Coalition for Addiction and Recovery Efforts (RICares), Faces and Voices of Recovery (FaVoR) and psycho-educational programs; and
o Individual and family support (where appropriate) services may be provided by any member of the

OTP health home team.

OTP Health Homes can provide support, education and resources to any family member as defined by the patient.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
With appropriate consents to release information, family and other supports of Health home participants may have access to relevant information contained in the electronic health record. Such information may be useful to supports for developing appopriate recovery plans and engaging patients in open discussions around needs and follow through. Families may also provide helpful collateral information that may guide the assessment and care planning for the individual.
Families may have need to access information through HIT in the event of emergency or potentially for legal issues. Family members can be made aware of provider's participation in Direct Messaging and in the event of an emergency can let responders know that there is information to be accessed in that manner.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

All members of the Health Home Teams

Description

All members of the Health Home teams may be involved in the provision of individual and family support services. While care managers may have primary responsibility, it is reasonable to assume that all of a Health home client's supports may have access to all team members. Doctors may include family members or patient advocates in their meetings with patients. Nurses may involve family in instructions for following care plans and discussions around medication adherence. Pharmacists may provide information to family and other supports on potential medication interactions and signs and symptoms of medication overdose.

Referral to community and social support services, if relevant

Definition:

Referral to community and social support services provides patients with a wide array of support services to help overcome barriers, increase self-management skills and achieve overall health. Appropriate referrals are driven by the assessment process and are noted on the patient's care plan in consultation with and agreement from the patient. The State assures appropriate referrals are made by monitoring the assessment, planning and care provided by OTPs.

Referral to community and social support involves facilitating access to assistance for individuals to address medical, behavioral, educational, social and community issues that may impact overall health. Such referrals are made through telephone or in person consultation and may include electronic transmission of requested data. Follow through on referrals will be the role of the healthcare liaison or the case manager, depending upon the type of referral. The types of community and social support services to which individuals will be referred may include, but are not limited to:

Primary care providers and specialists;
Wellness programs, including smoking cessation, fitness, weight loss programs or yoga;
Specialized support groups (i.e. cancer or diabetes support groups);
Recovery support services such as support groups, recovery coaches, 12 step groups;
Housing, including recovery housing;
Social integration opportunities including Recovery Centers;
Benefit attainment assistance;
State Nutrition Assistance Program (SNAP);
Office of Rehabilitation Services;
Social integration and social skill building programs;
Faith based organizations;
Community Mental Health Organizations;

Higher levels of care for addiction treatment, including IOP, PHP, residential or detox; Appropriate cultural support centers.
Referral to community and social support services may be provided by any member of the OTP health home team

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
Referrals to community and social support services can be made through Direct Messaging with any participating practices. It is important to note that for many of these programs, clinical detail in health records may not be needed or appropriate.
OTPs making referrals to the Rhode Island Department of Health's Chronic Condition Self Management Programs can use the established referral process. Releases are signed and a referral form is completed and then emailed to the DOH. DOH tracks the referrals and assists the patient in making and keeping appointments. Peers follow up on all referrals at least three times to insure that the patient is connecting to the service. These services include but are not limited to: arthritis exercise programs; arthritis walking with ease programs; certified diabetes and certified cardiovascular disease outpatient educators; Living Well Rhode Island; Diabetes Self-Management; Heatlh Smart Behaviors; Draw a Breath Asthma Program; Livestrong at the YMCA; Chronic Pain self management workshops; QuitWorks RI; YMCA's Healthy Lifestyles Behavior Change Program.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

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☐ **Pharmacists**

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☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

All members of the Health Home Teams

Description

With the exception of the pharmacist, it could be expected that referrals to community and social support services are made by any member of the Health Home team. For the Certified Diabetes Outpatient Educator and the Certified Cardiovascular Disease Outpatient Educator Programs, the referral must come from a physician.

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:

The RI flow chart depicts the Health Home process for "Alice" the opioid dependent HH client described in our previously submitted narrative. This chart identifies the process for individuals who may present in local hospital emergency departments. Through the HH process, it is expected that OTPs will work to increase their coordination of care with local hospitals and educate them on Health Home services. For an opioid dependent patient who presents in an ED, and assessment will be made as to whether that patient is currently enrolled in an OTP. If yes, they will be educated as to benefit of HH services, if no, outreach will be made to OTP hospital liaison who will offer OTP/HH services and coordinate appointment for assessment/intake. Assuming client is appropriate for treatment and decides to enroll in Health Homes, they would then be assigned to a Health Home team that may be focused on their primary chronic condition and meet with members of that team to create a recovery care plan. The patient would have access to the team nurse for any concerns, care needs and routine screenings. The patient would work with the team to have care coordinated with other health care providers which would include appointment scheduling, information sharing, medication reviews, follow-up. Case management would assist the client getting to appointments, connecting with other recovery support services, addressing needs and family engagement (if appropriate). If the primary chronic condition focus changes, the patient may transfer to a different team that addresses that particular condition if they choose to. As the client progresses in attaining recovery care goals, the focus of the team will be to continue care coordination, provide resource to the patient, and meet any

arising needs.
For patients already engaged in or self-referring to OTP services opportunity to participate in HH services will be offered and patients will progress through services as described above.

☑ **Medically Needy eligibility groups**

◉ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**

○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**

○ **All Medically Needy receive the same services.**

○ **There is more than one benefit structure for Medically Needy eligibility groups.**

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
Rhode Island will obtain information on re-admissions per 1000 member months for any diagnosis among eligible OTP clients from the Medicaid Data Warehouse.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
Rhode Island will annually assess cost savings using a
pre/post-period comparison. The assessment will include total Medicaid savings for the intervention group. The data source will be Medicaid claims and the measure will be
PMPM Medicaid expenditures. RI has current Medicaid data on all clients who received OTP services. RI also distributed a survey to OTP patients which included questions that assess their use of primary care physicians, specialty care, and Emergency rooms. This survey will be distributed again for a pre/post evaluation.

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).
BHDDH will actively work with Health Home providers, and specifically with the HIT coordinator, to increase use of the State's HIE - Current Care. BHDDH will capitalize on the progress made by our CMHO Health Homes in connecting to the HIE with provisions for compliance with 42 CFR Part II. Participation in the HIE means that programs will have ready access to health care information from other sources such as PCPs, hospitals, pharmacies and labs. While OTPs are required to access information through the State's Prescription Monitoring Program, not all prescription information is contained there (only certain schedules). Participation also means that OTPs can share information (with consent) so that other providers are aware of a client's participation in an OTP along with other relevant treatment information.
Information from MCOs and Medicaid will be provided to OTPs in routine reporting. MCOs will provide quarterly utilization reports along with next day notification of hospitalization. This will help OTPs effectively transition their patients and provide seamless care.
BHDDH will coordinate efforts with OTPs and the Department of Health's Chronic Disease Self Management program. Clients can be referred to these programs through email and tracked for follow through by DOH, with a report back to the referer.
BHDDH will use our the RIBHOLD system to provide outcome/trend data to providers and prevent dual

enrollment with other Health Homes.
OTPs will be supported in transforming into Health Homes through participation in statewide learning activities, monitoring and technical assistance. Physicians will have the opportunity to participate in DOH's Grand Rounds.
BHDDH will provide links to Health Home information on its website as a means of communication with providers and others.
OTPs will work with the HIT coordinator to develop systems for effective communication with patients such as texting, use of social media, twitter, and email alerts.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☐ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:
Admission per 1000 member months for any diagnosis among OTP Health Home Patients
Measure Specification, including a description of the numerator and denominator. Numerator: All OTP Health Home enrollees with a hospital stay during the measurement year Denominator: All OTP Health Home enrollees during the measurement year Data Sources: Medicaid Claims Frequency of Data Collection: ○ **Monthly** ○ **Quarterly** ◉ **Annually** ○ **Continuously** ○ **Other**

Emergency Room Visits

Measure:
ER visits per 1000 member months for any diagnosis among OTP Health Home Patients
Measure Specification, including a description of the numerator and denominator.

Numerator: All OTP Health Home enrollees with an ER visit during the measurement year
Denominator: All OTP Health Home enrollees during the measurement year
Data Sources:
Medicaid Claims
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Skilled Nursing Facility Admissions

Measure:
Admission per 1000 member months for any diagnosis among OTP Health Home Patients
Measure Specification, including a description of the numerator and denominator.
Numerator: All OTP Health Home enrollees with a skilled nursing facility admission during the measurement year
Denominator: All OTP Health Home enrollees during the measurement year
Data Sources:
Claims
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates
This information is available through analysis of Rhode island's Medicaid claims data. Hospital admissions rates for Health Home enrollees can be compared with rates for the same population in years prior to Health Homes implementation.

Chronic Disease Management
For new individuals of OTP health home services, the State will track hospital referrals and/or hospital liaison encounters as well as track face-to-face follow-up by a health team member within 2 days after hospitalization discharge. The state will also monitor the number of referrals/post discharge follow-up contacts that resulted in development of a care plan. DOH will monitor and report on the number of referrals made to the Chronic Conditions Self-Management Education Programs and the follow-through rates on those referrals. Claims data will provide the state with information on the utilization of specialty care providers for chronic disease, frequency of appropriate screening and potential medication adherence. This information will be gathered by the Administrative Level Coordinator and submitted to BHDDH on a quarterly basis.

Coordination of Care for Individuals with Chronic Conditions
Each Health Home enrollee will have an established medical home and access to the DOH's Chronic Conditions Self-Management Education programs, and access to all of the Health Home team staff, all of which will be documented in the Plan of Care to ensure coordination and follow up among team members and with the patient. Rhode Island OTPs already have established relationships and extensive experience coordinating with a wide range of community supports and
services. Rhode Island will use claims, encounter, and clinical registry data to collect information on patients' coordination of care, including postinpatient discharge continuation of care. The State will monitor updates to RI-

BHOLD to track changes in primary diagnoses, Axis IV diagnoses (e.g., housing problems, problems with access to health care services) and track individuals' self-reported co-occurring physical health conditions.

Assessment of Program Implementation
The State will monitor implementation through processes developed for our CMHO Health Home programs and include regularly occurring meetings of DHS, BHDDH, MCOs and OTPs. BHDDH will work with programs during the initial implementation phase to assess issues, barriers and opportunities. BHDDH will meet with staff to discuss the vision of Health Homes and how it fits into their service delivery model.
OTPs will provide monthly reports to BHDDH on staff composition and Health Home event data.
BHDDH will incorporate the same monitoring tool that was developed for the CMHO Health Homes which was well received by programs and reviewers. This tool includes a self assessment that is then compared to the scores of monitors. Monitors assess fidelity to the Health Home service model along with adherence to certification standards. This process will be conducted annually.

Processes and Lessons Learned
The State will develop tools to elicit feedback from OTPs to understand any operational barriers of implementing OTP health home services. The Administrative Level Coordinator will work with all OTPs to develop a quarterly report identifying processes, barriers and successes that will be submitted quarterly to BHDDH. In addition, the Coordinator will hold quarterly focus groups with Health Home patients and incorporate their feedback into reports which will guide program development.

Assessment of Quality Improvements and Clinical Outcomes
The State will utilize the quality process and outcome measures to assess quality improvements and clinical outcomes. As the
OTP Health Homes program progresses, Rhode Island anticipates implementing additional quality improvement and clinical
outcome measures, including but not limited to:
- Reducing rates of arrest and incarceration
- Increasing rates of employment/wages earned
- Increasing housing stability
- Reducing rates of positive urine drug screenings
- Engaging patients in documenting self-management goals and written self-management plans
- Reducing smoking rates
- Reducing use of high cost/high use categories such as pharmacy, lab,
and residential treatment

Estimates of Cost Savings

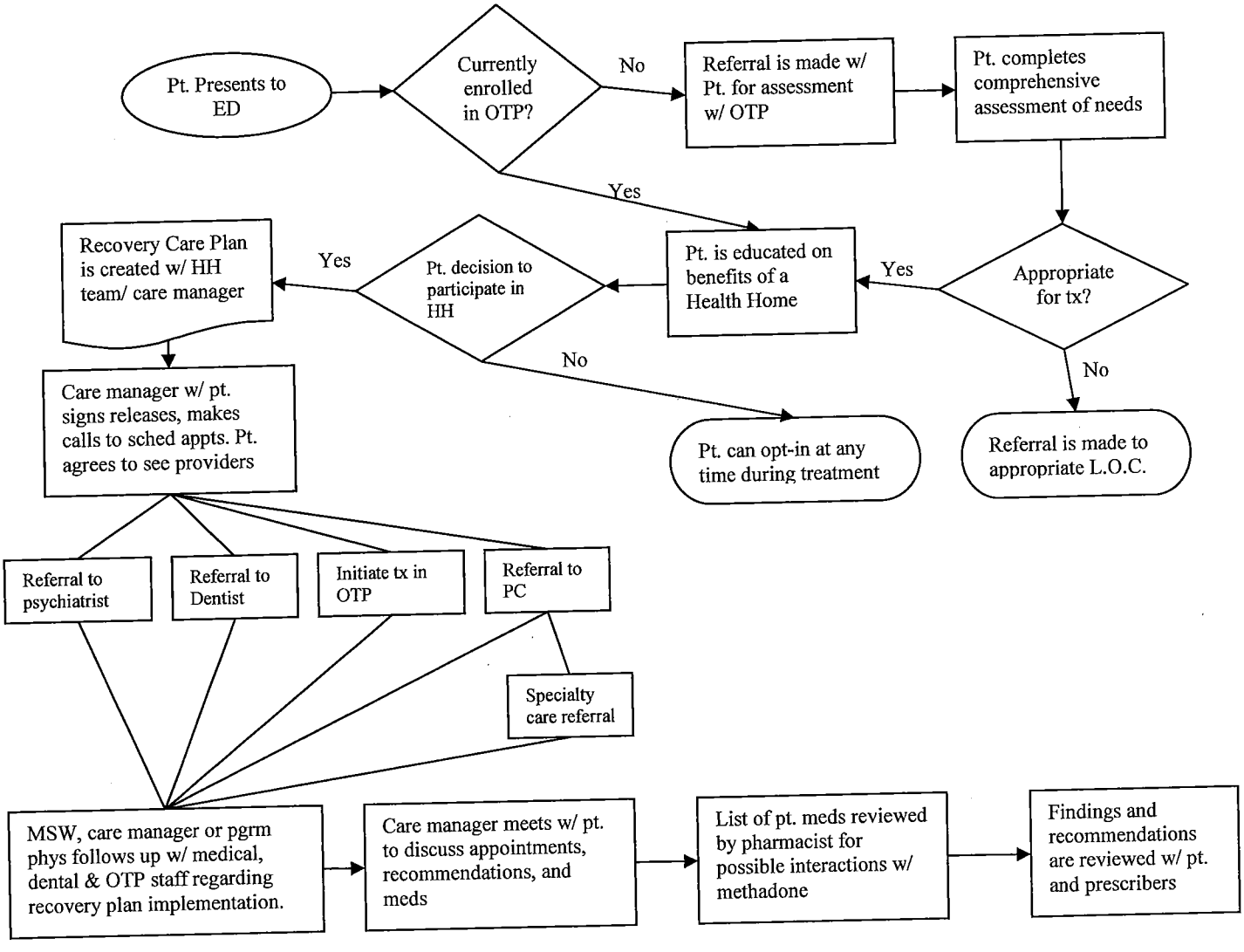
☐ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.
The State will annually perform an assessment of cost savings and service utilization of OTP health home service users pre/post implementation of OTP health home services. Savings calculations will be risk-adjusted, truncated claims of high-cost outliers annually exceeding five standard deviations of the mean.

OTP Health Home Flow Chart

Patient Background:

- 49 y/o Hispanic Female
- Opioid Dependence
- Suicidal ideation/major depressive disorder
- Hep C +
- Dental Problems
- No Primary Care Physician
- Presented to ED w/ suicidal ideation & Opioid WD



STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
Division of Behavioral Healthcare
14 Harrington Road
Cranston, RI 02920-3080

TEL: (401) 462-3292
TEL: (401) 462-4680
FAX: (401) 462-6078

Dear Rhode Island Medicaid Participant:

We believe that helping people lead healthier lives can greatly reduce the negative impacts of living with long-term substance use disorders and other medical conditions. That is why RI Medicaid and The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) are collaborating with Opioid Treatment Programs throughout the state to serve as Health Homes. Your Health Home offers you a Care Team of qualified healthcare professionals who can assist you in identifying your healthcare needs and achieving your wellness goals.

What your Health Home can do for you:

- Assist you in finding a family doctor if you don't already have one
- Assist you in obtaining mental health treatment or any type of special medical care that you might need
- Assist you in managing your medications and other medical treatments
- Provide you with access to health education opportunities addressing smoking, nutrition and physical activity
- Provide you with a case manager who can help you access other services and supports needed for your recovery
- Provide you with direct access to medical staff to respond to your needs and answer your questions

Research has shown that people with a Health Home receive a higher quality of care and achieve healthier outcomes. You have been enrolled with your current Opioid Treatment Program as your Health Home. The services you receive from your Health Home are covered under your RI State Medicaid Plan, so there is no charge to you, and participation in this program is voluntary.

Your Opioid Treatment Program Health Home team will be contacting you in the near future to discuss the benefits of this service and to answer any questions you may have. If at any time you wish to change Health Homes or decline Health Home services altogether, please inform your provider.

Sincerely,

Health Homes Analysis - 100/125/150 Patient Models

Staff Composition:

	FTE per 100	Hourly Rate w/o Fringe	Pay with 30% Fringe	Cost Per Postion	Total Costs 125:1 Model
Medical	0.25	140	$ 182	$ 378,560	$ 94,640
HH Coordinator	1	30	$ 39	$ 81,120	$ 81,120
Registered Nurse	1	30	$ 39	$ 81,120	$ 81,120
Case Manager	2	20	$ 26	$ 54,080	$ 108,160
Pharmacist	0.1	70	$ 91	$ 189,280	$ 18,928
Administrative Level Coordinator	0.1	40	$ 52	$ 108,160	$ 10,816
Staff Training	0.05	40	52	$ 108,160	$ 5,408
Technology/IT	0.05	60	78	$ 162,240	$ 8,112
Total FTE's	4.55				
Total Personnel					$ 408,304
Overhead:					
Facility Costs					$ 47,443
Office Costs					$ 43,866
Legal/Professional Costs					$ 42,883
Direct Costs					$ 26,355
Total Overhead					$ 160,547
Total Annual Costs per Team					$ 568,851
Average Individuals Per Team					125
Monthly Case Rate					**$ 379.23**
Weekly Case Rate					$ 87.52
Overhead rate					28.2%

*** The rates assume 100% utilization at all times.**